Allan Rawland
Director

Mission Statement

The County of San Bernardino Behavioral Health Programs strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities.

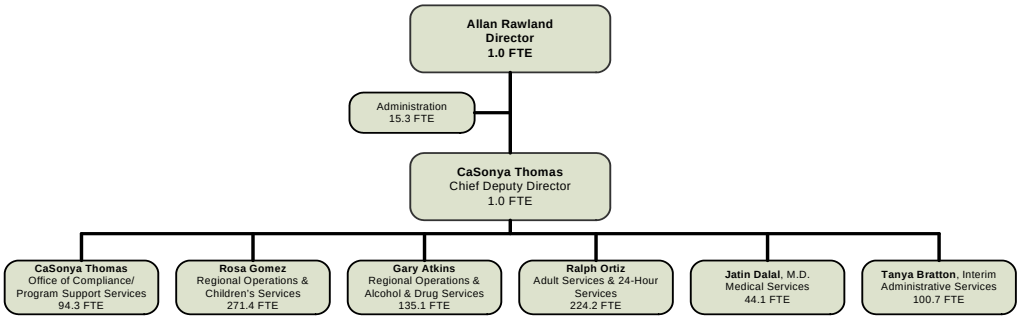
GOALS

INCREASE ACCESS FOR UNDERSERVED INDIVIDUALS

DEVELOP A STRATEGIC PLAN TO INTEGRATE HEALTH SERVICES THROUGHOUT THE COUNTY BY ENHANCING ACCESS TO CUSTOMER ORIENTED COMPREHENSIVE HEALTHCARE SERVICES

BEHAVIORAL HEALTH

ORGANIZATIONAL CHART



DESCRIPTION OF MAJOR SERVICES

The Department of Behavioral Health (DBH) provides mental health and substance abuse treatment to priority target populations in systems of care that are client-centered and culturally competent. Mental health treatment is provided to all age groups, with primary emphasis placed on treating severely emotionally disturbed children, families, and seriously mentally ill adults. Approximately 44,455 unduplicated clients are served through 42 county operated facilities and approximately 59 contract providers, public schools, and other community-based settings. Substance abuse treatment is provided by 2 county operated clinics and approximately 22 contractors. The major services components include outpatient, community outreach, self-help and support groups, homeless programs, employment services, case management, crisis and transitional residential assistance, augmented board and care placements, conservatorship services, supportive housing services and client transportation assistance.

Beginning in 2009-10, DBH will engage in a three-year planning effort to identify current community needs and priorities, assess departmental strengths and challenges and determine how the Mental Health Services Act (MHSA) can be used to meet local priorities.

Through this effort, DBH seeks to transform its service delivery system to better promote and support individuals that are diagnosed with a mental illness or substance abuse to live, work, learn and participate fully in their communities.

2008-09 SUMMARY OF BUDGET UNITS

	Appropriation	Revenue	Local Cost	Fund Balance	Staffing
General Fund					
Behavioral Health	197,547,716	195,704,963	1,842,753		799.6
Alcohol and Drug Services	23,105,034	22,955,576	149,458		87.5
Total General Fund	220,652,750	218,660,539	1,992,211		887.1
Special Revenue Funds					
Mental Health Services Act	83,879,310	48,109,482		35,769,828	-
Driving Under the Influence Programs	305,489	139,554		165,935	-
Block Grant Carryover Program	4,310,198	406,995		3,903,203	-
Court Alcohol and Drug Program	1,155,720	401,861		753,859	-
Proposition 36	5,025,776	4,994,336		31,440	-
Total Special Revenue Funds	94,676,493	54,052,228		40,624,265	-
Total - All Funds	315,329,243	272,712,767	1,992,211	40,624,265	887.1

GOALS, OBJECTIVES, AND PERFORMANCE MEASURES

GOAL 1: INCREASE ACCESS TO BEHAVIORAL HEALTH SERVICES FOR INDIVIDUALS THAT ARE UNDERSERVED OR WHO ARE RECEIVING A LIMITED LEVEL OF SERVICES.

Objective A: Continue to implement community based behavioral health care and treatment programs that serve as alternatives to more restrictive levels of care.

Objective B: Increase percentage of clients system-wide who are currently receiving Medi-Cal benefits.

Objective C: Create an assessment and treatment capability to be embedded within the Arrowhead Regional Medical Center (ARMC), DBH and Public Health integrated project (see Goal 2).

MEASUREMENT	2006-07 Actual	2007-08 Actual	2008-09 Target	2008-09 Estimate	2009-10 Target
1A. Percentage increase in clients served by crisis and early response programs (Juvenile Diversion Program, Crisis Walk-In Centers, Forensic Assertive Community Treatment, Assertive Community Treatment for Frequent Users of Hospital Care and Diversion Team at ARMC).	N/A	4,870	15%	15%	25%

Status

1A. In 2006-07, DBH began a series of programs designed to improve community services and supports over a three-year plan. The following programs are now fully operational:

- Community Crisis Response Team – 24/7 countywide
- Children's Wraparound Services/Success First
- Diversion Team at ARMC
- Crisis Walk-in Centers
- Forensic Assertive Community Treatment
- Older Adult Circle of Care Mobile Outreach & Intensive Case Management
- Assertive Community Treatment for Frequent Users of Hospital Care

Since inception these programs have diverted 4,870 clients from potential hospitalization, incarceration or more restrictive levels of care.

1B. Through a successful collaboration with the Transitional Assistance Department. DBH has obtained the services of 6 eligibility workers to assist with Medi-Cal eligibility determination.

DBH has held two trainings of staff regarding Medi-Cal/Supplemental Security Income (SSI) requirements and documentation and customer service to ensure proper assistance with clients with co-occurring substance abuse disorders in completing Medi-Cal SSI forms.

During 2008-09, the department plans to establish benefits teams composed of case managers, peer and family advocates, financial interviewers and eligibility workers to strengthen its support of this goal and objective.

2007-08 ACCOMPLISHMENTS

- *Received national award for the Integrated New Family Opportunities Program*
- *Received national award for the Transitional Aged Youth One Stop Center*
- *Opened the first 24/7Crisis Walk In Center in the High Desert*
- *Expanded Case Management Services and Mobile Outreach Case Management Services to Older Adults*
- *Launched mobile 24/7 Adult and Children's Crisis Response Team*
- *Implementation of all 9 MHSA Community Services and Support work programs*
- *Opening of all 3 new Transitional Aged Youth Centers countywide*
- *Approval of new Homeless Intensive Case Management and Outreach Program*

GOAL 2: DEVELOP INTEGRATED COUNTYWIDE COMMUNITY CLINICAL SERVICES.

Objective A: Develop unique strategic plans for integrating countywide, community clinical services offered by Public Health, ARMC, and the DBH into single, full scope area diagnostic and treatment centers.

MEASUREMENT	2006-07 Actual	2007-08 Actual	2008-09 Target	2008-09 Estimate	2009-10 Target
2A. Produce individual plans detailing patient demographics, site locations, systems integration, fiscal requirements and program design for two of the proposed integrated service models in the eleven identified catchment areas throughout the county.	N/A	N/A	New	75% complete July 2009	Complete January 2010

Status

2A. The Department of Public Health, ARMC, and DBH are in collaboration to integrate health services throughout the county by aligning clinical access to customer oriented comprehensive coordinated healthcare services. This clinical model would eliminate duplication of service provision and optimize resource effectiveness in the overall delivery of outpatient care. Recognition of patient needs for varying services would be immediate and result in a "warm hand off" to a qualified healthcare provider. Additionally, it allows common areas and support staff to be shared by all departments.

Eleven catchment areas have been defined and prioritized. The initial pilot for integrating services on a defined scale has occurred at Holt Clinic in Ontario where DBH staff were embedded into Public Health services and eligibility workers were strategically placed in Maternal/Child Health. The first complete prototype of full scope service is designed to integrate primary care from Westside Family Health Center, Maternal Health, Reproductive Health and the Women & Infant Care (WIC) Programs from Public Health and Individual/Group Counseling and "Club House" services from Behavioral Health. Incorporation of specialty pediatrics, laboratory, pharmaceutica, and radiology services would be incorporated to offer a complete outpatient diagnostic and treatment center.

Patient demographics have been identified, the physical sites (locations) are being reviewed, proposed program design is being drafted and clinic service adjacencies within the integrated model have been outlined. A key to the success of the integration process is integrated systems. Over the next year the integration team will continue to use the current clinic structure to test ideas relating to new systems. The team will test new technologies to determine which ones are more appropriate to accommodate the proposed methodology. This will allow the departments to outfit the inaugural integrated Clinic with vetted, mature technologies.

The team will continue to investigate the marketplace for the appropriate software and systems integration services that might be candidates for our integrated model. Due to the maturity of the marketplace for systems targeted to integrated clinics, it is anticipated that the development of in-house systems will play a crucial role in the success of the integrated clinic services model.

San Bernardino County is a pioneer in this concept of operations. The three health services within the county conduct integration committee meetings monthly to identify, develop, assign responsibility, and report on critical components of this work in progress. Much of the research has been completed. Specific implementation plans with target dates and fiscal projections of operational costs and one-time and ongoing funding requirements for the full scale service model are anticipated to be complete by midyear of 2009-10. Strategic planning and implementation of integrated services will be ongoing and will incorporate process change from lessons learned, fluctuating demographics and area dynamics throughout the eleven catchment areas within the county.

GOAL 3: INCREASE ACCESS AND REDUCE BEHAVIORAL HEALTH DISPARITIES AMONG THE DIVERSE RACIAL, ETHNIC AND CULTURAL COMMUNITIES IN SAN BERNARDINO COUNTY.

Objective A: Complete a study of the population to identify the cultural and linguistic needs and barriers to improving access to services.

Objective B: Increase number of clients among specified ethnic/cultural groups that are currently underserved.

MEASUREMENT	2006-07 Actual	2007-08 Actual	2008-09 Target	2008-09 Estimate	2009-10 Target
3B. Medi-Cal penetration rates for underserved ethnic groups. (2005-06 Baseline: African American 7.86%; Asian/Pacific Islander 4.03%; Hispanic 3.26%)	African American 7.7% Asian 4.0% Hispanic 4.2%	African American 8.09% Asian 4.3% Hispanic 3.3%	African American 8.2% Asian 4.4% Hispanic 3.5%	African American 8.2% Asian 4.4% Hispanic 3.5%	African American 8.3% Asian 4.5% Hispanic 4.0%

Status

3A. The access study is a collaborative effort between the department, an academic institution and a community organization. The study will target African-American, Hispanic and Asian/Pacific communities to determine the barriers that currently exist for each of these populations as it relates to the utilization of mental health services. Moreover, the study will provide us with strategies and recommendations to address the identified barriers in an effort to improve the availability and delivery of culturally and linguistically appropriate services to the specific ethnic groups. The department will be implementing three programs that are ethnic specific through the Prevention and Early Intervention component. The programs include:

- Resilience Promotion in African-American Children: Will promote resilience in African American children in order to mediate the development of Post Traumatic Stress Disorder, Mood Disorders, other Anxiety Disorders, Substance Abuse, and Psychotic Disorders through a 12 week intensive program followed by ongoing weekly interventions.
- American Indian Resource Center: Will provide culturally specific Prevention and Early Intervention (PEI) services to Native Americans in one location such as Healing Circle, Sweat Lodge, Peer to Peer, and a medicinal garden.
- Family Resource Center: Will reduce stigma/discrimination by providing a variety of PEI services and programs in a community-based setting.
- Promotores de Salud: Will train identified community leaders to provide a personal contact or liaison to mental health resources and programs within the community without having to visit a traditional mental health treatment services site as well as help reduce the stigma that surrounds that ethnicity.

In addition, the department is participating in a California Institute for Mental Health (CIMH) learning collaborative that will further identify strategies on how to reduce disparities within the county.

3B. As is the case with other California counties, specific ethnic groups in San Bernardino County are served at rates that are disproportionately low compared to their representation in the Medi-Cal beneficiary population. Penetration rates are determined by the proportion of Medi-Cal beneficiaries receiving at least one mental health contact within each fiscal year. In 2005-06, the Medi-Cal penetration rates for African Americans, Asian/Pacific Islanders and Hispanics were 7.86%, 4.03%, and 3.26%, respectively. Our objective is to increase the penetration rates for these ethnic groups incrementally each year to match or exceed that of the averages for California's "large counties."

GOAL 4: DEVELOP AN INTEGRATED PLAN FOR SYSTEM TRANSFORMATION IN ACCORDANCE WITH THE MHSA FRAMEWORK.

Objective A: Transform the existing community based system through the use of MHSA funds in both county and contract operations.

Objective B: Implement all seven components of the MHSA and Integrated Plan by 2012-13.

Objective C: Complete Integrated Information Systems Master Plan by 2012-13.

MEASUREMENT	2006-07 Actual	2007-08 Actual	2008-09 Target	2008-09 Estimate	2009-10 Target
4B. Percentage completion of approved MHSA components and Integrated Plan.	N/A	25%	75%	75%	100%

Status

4A. In October 2008, the California Department of Mental Health released a framework for county mental health programs to develop a three-year program and expenditure plan (Integrated Plan). The Integrated Plan covers the period of 2010-11 through 2012-13, and is due to the state by March 1, 2010. The intent of plan is to integrate MHSA into the larger mental health system. In light of decreases in other financial resources, the department is using this framework as an opportunity to redesign core programs and convert existing county clinics and selected contract providers to Full Service Partnerships (FSP). The FSP is a collaborative relationship between the county and the client, and when appropriate the client's family, through which the county plans for and provides a full spectrum of community services so that the client can achieve identified goals.

4B. Currently DBH has obtained state approval for four (Community Program Planning, Community Services and Support, Prevention & Early Intervention, Workforce Education and Training) of the seven components (Community Program Planning, Community Services and Support, Workforce Education and Training, Prevention & Early Intervention, Capital Facilities and Technology, Innovation and Permanent Supportive Housing) of the MHSA.

The aim for 2009-10, is to submit plans for the three remaining components and obtain state approval for implementation. Additionally, DBH intends to submit its Integrated Plan to combine services and supports funded by the MHSA with the existing system for a transformed system of care effective 2013-14.

4C. MHSA information system component funding will assist with replacement of the department's practice management and billing system by 2009-2010, an integrated data warehouse in 2010-2011, and an electronic mental health record in 2011-2012.

GOAL 5: IMPLEMENT STRATEGIES FOR SUCCESSFUL QUALITY IMPROVEMENT IN BEHAVIORAL HEALTH.

Objective A: Develop a plan that utilizes an educational approach to instill knowledge and apply system and process improvements.

Objective B: Continue progress towards achieving a significant, measurable reduction of service disallowances department-wide.

MEASUREMENT	2006-07 Actual	2007-08 Actual	2008-09 Target	2008-09 Estimate	2009-10 Target
5B. Percentage reduction of service disallowances in Medi-Cal reviews conducted by the Quality Management Division.	N/A	N/A	10%	10%	10%

Status

5A. There are eight areas of performance represented in the DBH Quality Improvement Plan. 100% of the goals as specified in the plan will be implemented during 2008-09. The implementation of these goals will ensure continuous quality improvement efforts are ongoing department-wide. As a result, areas of improvement will be identified for administrative review, solutions formulated and measurable interventions implemented for baseline review. These efforts will translate into more customer focused services, increased quality of care and will provide baseline data for program related decision making to key leadership.

5B. Over the last 18 months, ongoing efforts to reduce department wide disallowances have resulted in a cumulative reduction of 11.26%, bringing the department average to 12.74% overall from 24%. Currently, 2008-09 figures indicate that the system will maintain the 10% reduction in disallowances during this fiscal year. As the department gets closer to the base goal of 5% department wide, disallowance percentages above the 10% maintenance goal, will be less over time as we approach the threshold goal of 5% annually.

2009-10 REQUESTS FOR ADDITIONAL GENERAL FUND FINANCING

The department is not requesting any additional general fund financing for 2009-10.

2009-10 PROPOSED FEE ADJUSTMENTS

The department is not requesting any proposed fee adjustments for 2009-10.

If there are questions about this business plan, please contact Allan Rawland, Director, at (909) 382-3133.